

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1711

CERTIFICATE OF DEATH

01691

M

PLACE OF DEATH
a. COUNTY

CALVERT

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

PRINCE FREDERICK 1 WK.

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

CALVERT COUNTY HOSPITAL

064
3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

FEB. 7 1961

Month

Day

Year

5. SEX

6. COLOR OR RACE

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

JAN. 7, 1899

9. AGE (in years
last birthday)

62 yrs.

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months

Days

Hours

Min.

10e. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

CHARLES R. BELT

14. MOTHER'S MAIDEN NAME

HELEN M. DUKE

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)

NO

16. SOCIAL SECURITY NO.

17. INFORMANT

MRS HELEN ROONEY - DR. CREEK, MD

INTERVAL BETWEEN
ONSET AND DEATH

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

CARCINOMA of Colon (Splenic Flange 1490)

153.1 DUE TO

Conditions, if any, which
give rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

19. WAS AUTOPSY
PERFORMED?

YES NO

20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. 20d. INJURY OCCURRED
p.m. 19 While Not While
at work at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from Jan. 20, 1961, to Feb. 7, 1961, that (I) (we) last
saw the deceased alive on Feb. 6, 1961, and that death occurred at M. from the causes and on the date stated above.

22e. SIGNATURE

22c. PHYSICIAN'S
NAME (Type)

23b. DATE THEREOF

REMOVAL (Specify)

BURIAL

24 FUNERAL DIRECTOR'S SIGNATURE

FEB. 9, 1961

23c. NAME OF CEMETERY OR CREMATORIAL

ADDRESS

CHRIST CHURCH CEM.

23d. LOCATION (City, town or county)

(State)

CALVERT CO., MD

ATTENDING
PHYS.

MED.
DIRECTOR

STAFF
PHYS.

22d. ADDRESS

PRINCE FREDERICK MD

22b. DATE
SIGNED

2/7/61

A. G. Harkness & Son - Mutual, Md.

25e. REC'D BY REGISTRAR

FEB 9 '61

DATE

25b. REGISTRAR'S SIGNATURE

Arthur S. Kraus

8
VR A15 (4)
15M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 01692

1. PLACE OF DEATH o. COUNTY <i>Calvert</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Prince Frederick</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Front Royal</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Calvert Co.</i>		d. STREET ADDRESS <i>Front Royal</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Jefferson A. Brooks</i>		First	Middle
		Last	4. DATE OF DEATH 2 11 1961
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <i>1/19/60</i>
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) yrs. <i>1</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Md</i>
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <i>Calvin Brooks</i>		14. MOTHER'S MAIDEN NAME <i>Carrie Lydia Mae</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT <i>Calvin Brooks, Father</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>917.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>Wheezing from lung of 20 days when</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Not of coffee was knocked over on me</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING CAUSE OR CONTRIBUTING CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Not of coffee knocked over salt up</i>	
20c. TIME OF INJURY Month, Day, Year Hour <i>5</i> p. m. <i>2 10 1961</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>
20f. (City or town) <i>Calvert</i>		(County) (State)	
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at <i>6 A.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>H. W. Ward</i>		ADDRESS (Street, city or town, state) <i>Front Royal</i> DATE SIGNED <i>1961</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>2-12-61</i>		22b. DATE THEREOF <i>2-12-61</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Plum Point</i>
22d. LOCATION (City, town, or county) <i>Calvert, Md.</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>P. E. Sewell, Bruce Frederick,</i>		ADDRESS	24a. REC'D BY REGISTRAR DATE <i>FEB 14 '61</i>
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Khan</i>	

TO HOSPITAL may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1713

CERTIFICATE OF DEATH

Reg. Dist. No.

01693

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		2. USUAL RESIDENCE [Where deceased lived. If institution, Residence before admission] a. STATE <i>Maryland</i>	
b. CITY OR TOWN [If outside corporate limits, write RURAL and give nearest town] <i>R. Beach</i>		c. LENGTH OF STAY IN 1b <i>1 week</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>315 Bay Ave</i>		d. STREET ADDRESS <i>1 315 Bay Ave</i>	
3. NAME OF DECEASED (Type or print) <i>Alonzo J. & Chrismond</i>		4. DATE OF DEATH <i>2</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 3, 1870</i>
9. AGE (In years last birthday) <i>90</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. Year <i>1961</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Bulder</i>	
10c. BIRTHPLACE (State or foreign country) <i>Wash D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Oscar Chrismond</i>		14. MOTHER'S MAIDEN NAME <i>Jane Beardson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>NONE</i>	
17. INFORMANT <i>B.B. Weir, M. Beach</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>442X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>Cardio vascular and disease</i> <i>Had Cancer of left ear</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Had an abdominal aeurysm</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Doy, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Jane</i> , 19 <i>60</i> , to <i>2/21/61</i> , 19 <i>61</i> , that I last saw the deceased alive on <i>2/2/61</i> , 19 <i>61</i> , and that death occurred at <i>243 B</i> M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>H.W. Ward</i>		ADDRESS (Street, city or town, state) <i>Owings Md.</i> DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>2-28-61</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>FORT LINCOLN</i>
22d. LOCATION (City, town, or county) <i>BELDENSBURG, MD.</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W.W. Chambers Co. 517 11th St. S.E. DC</i>		24a. REC'D BY REGISTRAR <i>DATE FEB 28 '61</i>	24b. REGISTRAR'S SIGNATURE <i>John H. Ward</i>

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1714

CERTIFICATE OF DEATH

01694

1. PLACE OF DEATH a. COUNTY CALVERT MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD b. COUNTY CALVERT	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) PRINCE FREDERICK c. LENGTH OF STAY IN IB 2 WKS		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HUNTINGTOWN	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) CALVERT COUNTY HOSPITAL		d. STREET ADDRESS —	
3. NAME OF DECEASED (Type or print)	First JANIE	Middle ELIZABETH	Last GIBSON
4. DATE OF DEATH	Month Feb.	Day 21	Year 1961
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> b. DATE OF BIRTH MAY 30, 1876	8. AGE (In years last birthday) 84 yrs.
9. IF UNDER 1 YEAR Months — Days —	10. IF UNDER 24 HRS. Hours — Min. —		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (County & State, or foreign country) HUNTINGTOWN, MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOSEPH R. GIBSON		14. MOTHER'S MAIDEN NAME ANNIE MARY SHECKLELLS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? No		16. SOCIAL SECURITY NO. UNKNOWN	
17. INFORMANT WALTER GIBSON - HUNTINGTOWN, MD.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac decompensation DUE TO 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterios clistic Pl. disease (c) Fracture of left hip DUE TO — PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Fall in home	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 48 hours 10 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) —		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) Fall in home	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 12 No 2/8 1961		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home 20f. (City or town) Huntingtown - Calvert - Md. (County) — (State) —	
21. I certify that (I) (this hospital) attended the deceased from 2-8 to 2-21 , 19 61 , that (I) (we) last saw the deceased alive on 2-21 , 19 61 , and that death occurred at — M, from the causes and on the date stated above.		22a. SIGNATURE Ben Jett 22b. DATE SIGNED 2/21/61	
22c. PHYSICIAN'S NAME (Type) —		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS Prince Frederick, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Feb. 24, 1961 23c. NAME OF CEMETERY OR CREMATORIAL MIRANDA CEMETERY 23d. LOCATION (City, town or county) HUNTINGTOWN - MD. (State) —	
24. FUNERAL DIRECTOR'S SIGNATURE A.A. HARKNESS & SON - MUTUAL, MD.		ADDRESS — 25a. REC'D BY REGISTRAR — 25b. REGISTRAR'S SIGNATURE Arthur S. Frazee DATE FEB 27 '61	

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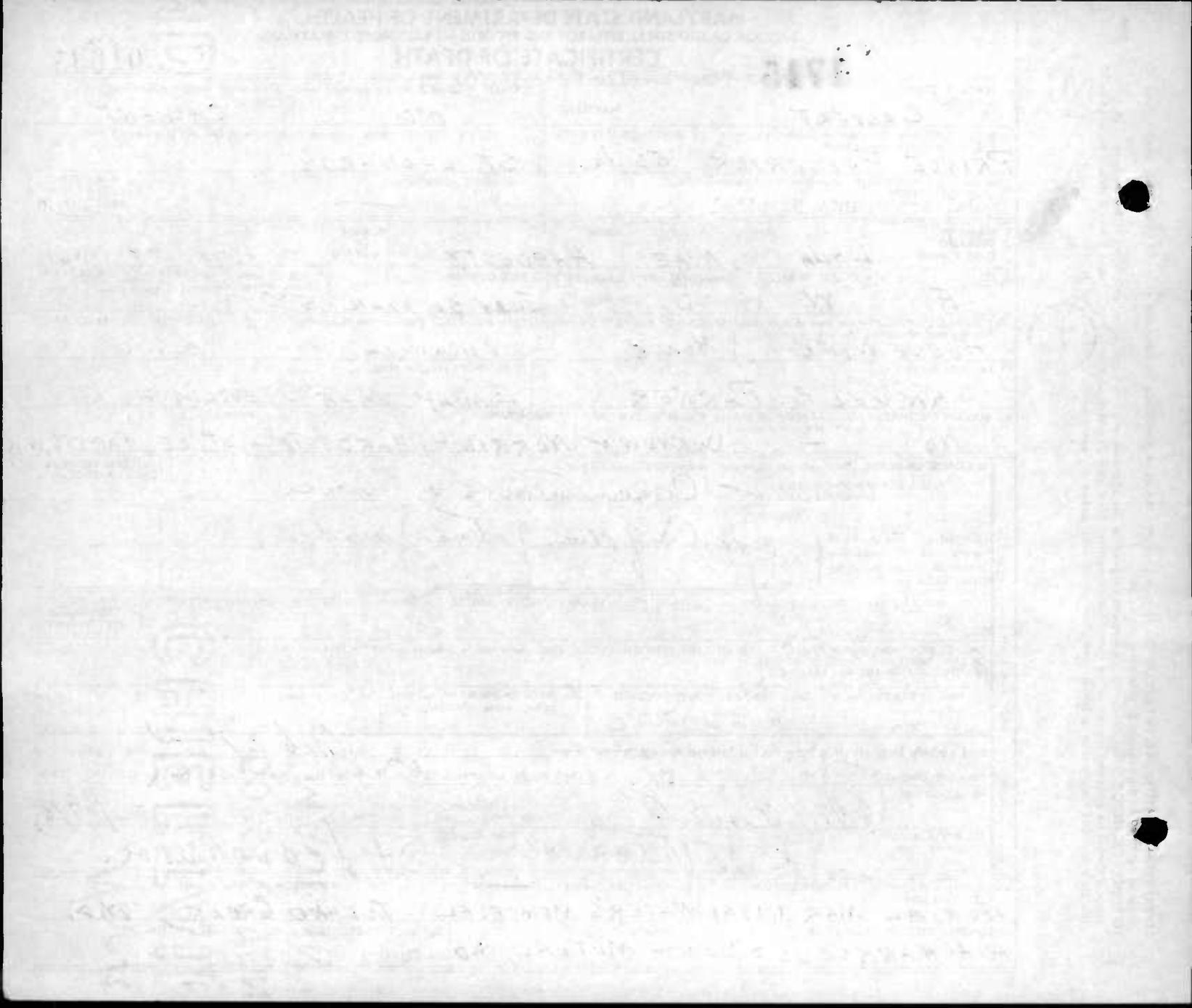
VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01695

1. PLACE OF DEATH a. COUNTY		1715 Item 1d Film 0288 3/7/61		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)		
CALVERT		MARYLAND		a. STATE MD		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		b. COUNTY CALVERT		
PRINCE FREDERICK		53 da		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Calvert County Hospital		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	
LOLA		MAE	HARDESTY		FEB. 27 1961	
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH		
F		W		JULY 24 1902 58 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		
HOUSEWIFE		HOME		VIRGINIA		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?		
SAMUEL B. PARKER		EMILY MAE STERLING		U.S.A.		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		
No		UNKNOWN		NORRIS G. HARDESTY - ST. LEONARDS, MD		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a):		Cerebrovascular - & Liver				
1715 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		DUE TO (b) from Ca of liver & uterus Jaundice				
(c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		
19				Feb 27 1961		
21. I certify that (I) (this hospital) attended the deceased from _____ to _____, that (I) (we) last saw the deceased alive on _____, and that death occurred at _____, from the causes and on the date stated above.		19 to Feb 27 1961				
22a. SIGNATURE		M.D. ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS		ST LEONARD, MD		2/27/61
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City, town, or county) (State)
BURIAL		MAR. 1, 1961		WATER'S MEMORIAL		ISLAND CREEK, MD
24. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
A. A. HARKNESS & SON - MUTUAL, MD				DATE MAR 2 '61		Arthur S. Trahan



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
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MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01696

1716

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Prince Frederick</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Plum Point,</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Co. Hospital</i>		d. STREET ADDRESS <i>1</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Clarence</i>	First	Middle	Last
4. DATE OF DEATH <i>2 5 1961</i>	Month	Day	Year
S. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-19-1903</i>
9. AGE (In years last birthday) <i>57 yrs.</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>	11. KIND OF BUSINESS OR INDUSTRY <i></i>	12. BIRTHPLACE (State or foreign country) <i>Maryland</i>
13. FATHER'S NAME <i>Joseph Holland</i>	14. MOTHER'S MAIDEN NAME <i>Hula Hurley</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i></i>	16. SOCIAL SECURITY NO. <i>213-01-8082</i>	17. INFORMANT <i>Beatrice Holland, Huntington</i>	Address <i></i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>331X</i>		INTERVAL BETWEEN ONSET AND DEATH <i>8 hours</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <i></i>			
(c) DUE TO <i></i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Feb 21 1961</i> to <i>Feb 2 1961</i> , that (I) (we) last saw the deceased alive on <i>19</i> and that death occurred at <i>2 AM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>P. E. J. T.</i>		22b. DATE SIGNED <i></i>	
22c. PHYSICIAN'S NAME (Type) <i>PAGE C. JEFF</i>		22d. ADDRESS <i>PRINCE FREDERICK</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>2-8, 6-1</i>		23b. DATE THEREOF <i>5 St. Edmonds</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i></i>		23d. LOCATION (City, town, or county) (State) <i>Sunderland, Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>P. E. Sewell, Prince Frederick,</i>		25a. REC'D BY REGISTRAR DATE <i>FEB 10 '61</i>	
ADDRESS <i></i>		25b. REGISTRAR'S SIGNATURE <i>Carrie S. Kraus</i>	

2210

HEARDO BY SHINDO

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

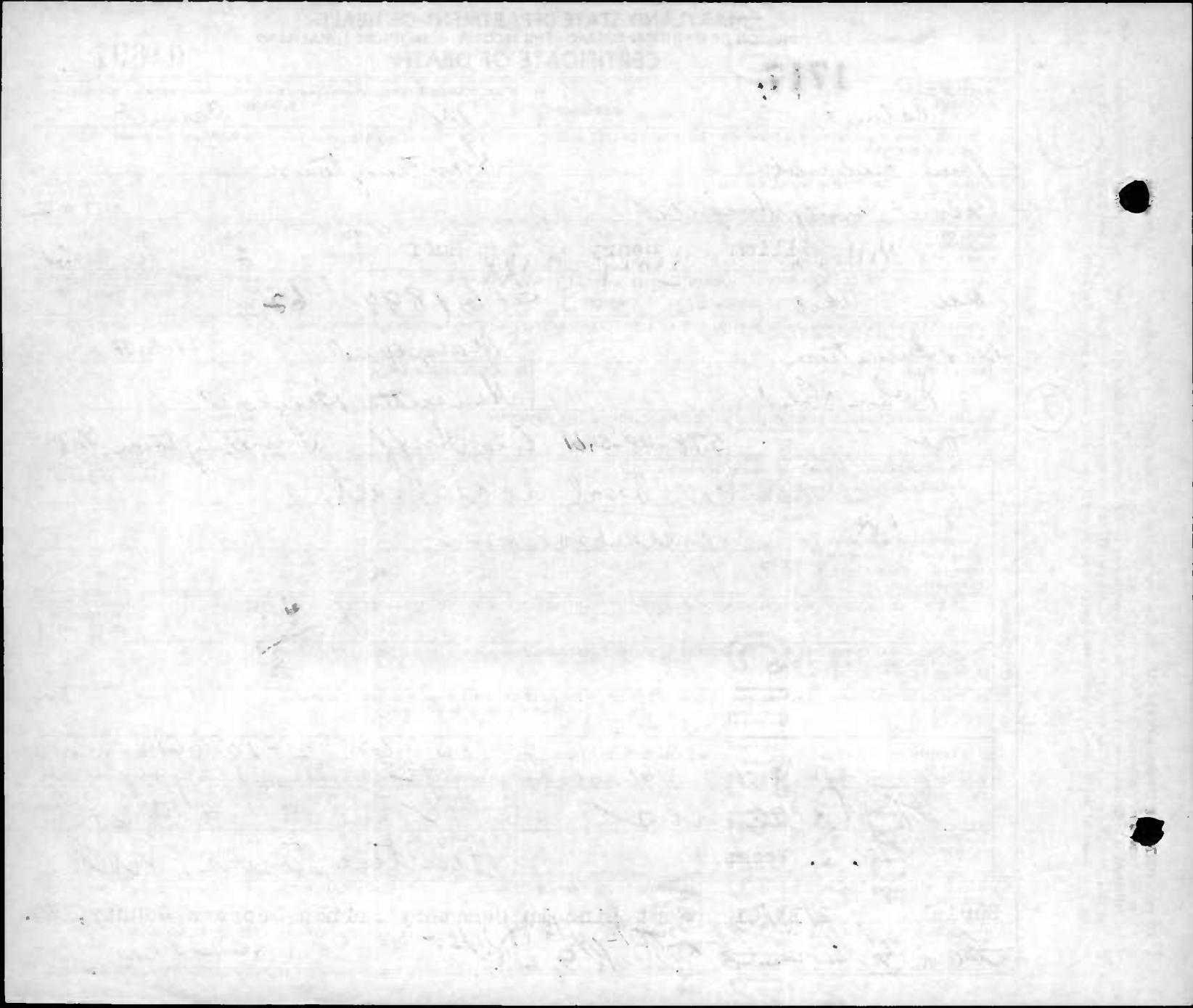
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01697

1. PLACE OF DEATH a. COUNTY		1717 Maryland		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		Md.		b. COUNTY		Calvert			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
Prince Frederick				Huntingtown									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Calvert County Hospital											
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year					
William		Henry	Huff	Huff	2	10	19	61					
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DAY & BIRTH	9. AGE (In years to birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.						
Male		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Feb 6, 1899	62 yrs.	Months	Days	Hours	Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?				
Wood Furniture						Maryland			U.S.A.				
13. FATHER'S NAME		John Huff		14. MOTHER'S MAREN NAME		Henrietta Benson		Address					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT							
no				578-48-5461		Ala Huff							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]		INTERVAL BETWEEN ONSET AND DEATH											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cerebral accident.											
231X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		DUE TO											
		(b)		arteriosclerosis									
		DUE TO											
(c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from 2-10 1960 to 2-10 1961, that (I) (we) lost saw the deceased alive on 2-10 1961, and that death occurred at 945 M, from the causes and on the date stated above.													
22a. SIGNATURE G. J. Weems		M.D.		ATTENDING PHYS.		MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2/10/61					
22c. PHYSICIAN'S NAME (Type) G. J. Weems		22d. ADDRESS		Huntingtown, Md									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/13/61		23c. NAME OF CEMETERY OR CREMATORIUM Fort Lincoln Cemetery		23d. LOCATION (City, town, or county) Prince Georges County, Md.		(State)					
24. FUNERAL DIRECTOR'S SIGNATURE The S. H. funeral S. Wash 9, D.C.		25a. RECORD BY REGISTRAR 2001-04-10 11:30 AM DATE		25b. REGISTRAR'S SIGNATURE Arthur S. Trauma									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

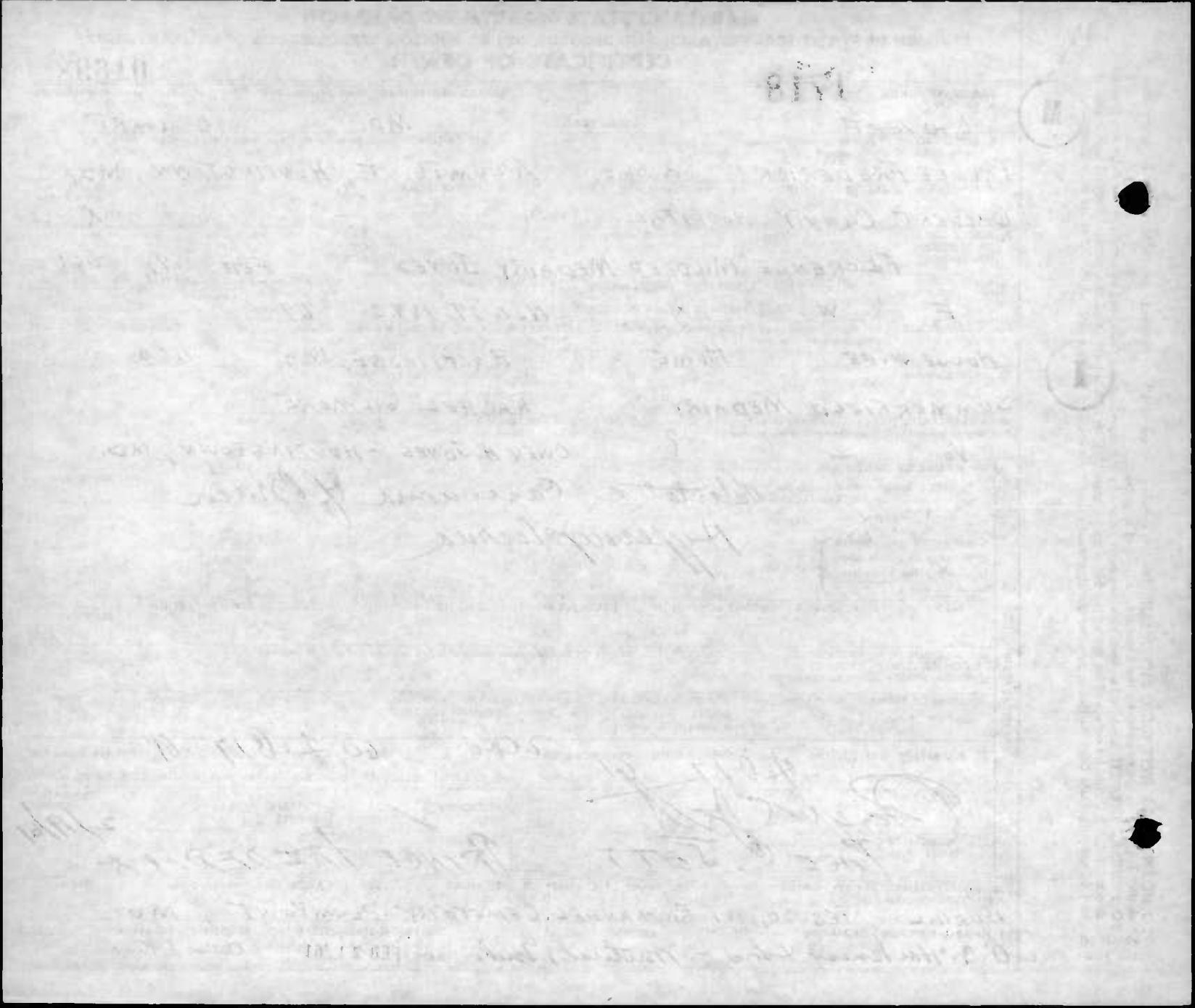
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01698

1. PLACE OF DEATH e. COUNTY		1718		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)	
CALVERT		MARYLAND		e. STATE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		b. COUNTY	
PRINCE FREDERICK		2 Mos.		CALVERT	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		X PLUM POINT, HUNTINGTOWN, MD.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
CALVERT COUNTY HOSPITAL		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM?	
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH
FLORENCE MILDRED MEDAIRY JONES					FEB. 17, 1961
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH	9. AGE (In years last birthday) IF UNDER 1 YEAR	
F		W	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> NOV. 27, 1893	Months	Days
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)	
HOUSE WIFE		HOME		BALTIMORE, MD.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
SUMMERFIELD MEDAIRY		RACHEL GILMORE		USA.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or date of service)		16. SOCIAL SECURITY NO.		Address	
No		?		OWEN H. JONES - HUNTINGTOWN, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Melanotic Carcinoma of Brain			
219X Conditions, if any, which give rise to immediate cause (b), stating the underlying cause last.		DUE TO Hypernephroma			
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED?			
20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour e.m. p.m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from		20d.	1960 to 1961	21. I certify that (I) (we) last saw the deceased alive on	21. I certify that (I) (we) last saw the deceased alive on
22e. SIGNATURE		21. I certify that (I) (we) last saw the deceased alive on			
22c. PHYSICIAN'S NAME (Type)		22. ADDRESS			
PAGE C. SETT		PRINCE FREDERICK			
23e. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORIAL	23d. LOCATION (City, town or county)	(State)
BURIAL		1961	EMMANUEL CEMETERY	PLUM POINT, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE	
A. G. Starkness & Son - Mutual, Md.				Arthur S. Kraus	
B.P.			DATE FEB 21 '61		



TO HOSPITAL may be retained by the hospital or attending physician and completely filled in by the funeral director. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1719

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01699

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Prince Frederick</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Lusby, Md</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Calvert Co. Hosp.</i>		d. STREET ADDRESS <i>1</i>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <i>Baby Boy</i>	Middle <i>Lee</i>	Last <i>Lee</i>	4. DATE OF DEATH Month <i>2</i> Day <i>16</i> Year <i>1961</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2-12-61</i>	9. AGE (In years last birthday) yrs. <i>4</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Md</i>
12. CITIZEN OF WHAT COUNTRY?				
13. FATHER'S NAME <i>Thomas H Lee</i>		14. MOTHER'S MAIDEN NAME <i>mae Beverly</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Thomas H. Lee, Lusby, Md</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>776X</i>		DUE TO <i>Prematurity (2 lb.)</i>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) <i>2/12 1961 2/16 1961</i>
21. I certify that (I) (this hospital) attended the deceased from <i>2/16 1961</i> to <i>2/16 1961</i> , that (I) (we) last saw the deceased alive on <i>19 61</i> and that death occurred at <i>M</i> , from the causes and on the date stated above.		22b. DATE SIGNED		
22a. SIGNATURE <i>R. J. Villareal</i>		M.D. <input type="checkbox"/> ATTENDING PHYS. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
22c. PHYSICIAN'S NAME (Type) <i>R. J. Villareal</i>		22d. ADDRESS <i>5th Avenue</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>2-17-61</i>		23b. DATE THEREOF <i>2-17-61</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>St. Johns</i>	23d. LOCATION (City, town, or county) <i>Lusby</i> (State) <i>Md</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>P. E. Sewell, Bruce Frederick</i>		ADDRESS <i>2064313XVI</i>	25a. REC'D BY REGISTRAR <i>FEB 23 '61</i>	25b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01700

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Huntingtown</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Huntingtown</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Carl</i>	Middle <i>C</i>	Last <i>Morsell</i>
4. DATE OF DEATH	Month <i>July</i>	Day <i>15</i>	Year <i>1961</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 5</i>
9. AGE (In years last birthday) <i>46 yrs.</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>	11. KIND OF BUSINESS OR INDUSTRY	12. BIRTHPLACE (State or foreign country) <i>Maryland</i>
13. FATHER'S NAME <i>Garey Morsell</i>	14. MOTHER'S MAIDEN NAME <i>Amonia Reid</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.	17. INFORMANT <i>Mrs Amonia Reid, Huntingtown, Md.</i>	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>325.2</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <i>Pneumonia</i> (c) DUE TO <i>Upper Respiratory Infection</i> DUE TO <i>Congenital Malformation</i>		INTERVAL BETWEEN ONSET AND DEATH <i>immediate</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>215</i> , 19 <i>61</i> , to <i>19</i> , 19 <i>61</i> , that (I) (we) last saw the deceased alive on <i>215</i> , 19 <i>61</i> , and that death occurred at <i>10 PM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Garey M. Jett</i>	M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>2/20/61</i>	
22c. PHYSICIAN'S NAME (Type) <i>PAGE O. JETT</i>	22d. ADDRESS <i>Prince Frederick</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>3-19-61</i>	23b. DATE THEREOF <i>3-19-61</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Elmwood</i>	23d. LOCATION (City, town, or county) (State) <i>Calvert</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>P. E. Seawell, Prince Frederick,</i>	ADDRESS	25a. REC'D BY REGISTRAR DATE <i>FEB 23 '61</i>	25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>

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